126th Maine Legislature
First Regular Session

COMMITTEE RULES OF PROCEDURE

NOTICE REGARDING COMMITTEE RULES OF PROCEDURE

Joint Rule 304 provides that at the beginning of each legislative biennium, the presiding officers shall establish procedures that govern public hearings, work sessions and confirmation hearings. Once established, copies of the procedures must be sent to the committees, the Secretary of the Senate, the Clerk of the House and the Executive Director of the Legislative Council. A committee by majority vote may make exceptions to the rules and notify the presiding officers of exceptions to the rules. Final committee rules must be posted and made available upon request at all public hearings and work sessions.

The rules of procedure in committee are the same as the rules of the Senate and the House of Representatives to the extent applicable. Committee procedures must be consistent with these rules.

1. Chair Presides. Pursuant to Joint Rule 302, the Senate chair shall preside and in the Senate chair's absence, the House chair shall preside and, thereafter, as the need may arise, the chair shall alternate between the members from each chamber in the sequence of their appointment to the committee.

2. Quorum. Pursuant to Joint Rule 306 and Title 3, section 165, a quorum is 7 members, and a quorum must be present to start a meeting or at any time a vote is taken, other than on a motion to adjourn. A quorum is not required to continue a meeting. If a quorum is present, but there is not a Senator among those present, the committee may take a vote only with the authorization of the President of the Senate.

3. Attendance. It is each committee member's responsibility to notify the committee clerk whenever the member is unable to attend a public hearing or work session.

4. Scheduling of hearings and work sessions. Joint Rules 304 and 305 govern the scheduling and notice of public hearings and work sessions.

A. The Senate chair with the agreement of the House chair and the assistance of committee staff shall schedule legislative documents for public hearings and work sessions. If the chairs do not reach an agreement, the committee shall decide by majority vote of the membership.

B. In accordance with Joint Rule 305, the presiding officers jointly establish authorized meeting days. The committee may meet only on authorized meeting days unless the presiding officers authorize an exception in writing.

C. The presiding officers have jointly established authorized meeting times to begin at 1pm on legislative session days and 10am on non-legislative session days. If the committee wishes to change the established meeting time, they must request an exception from the presiding officers.

7. Procedures for public hearings. The purpose of a public hearing is to invite public comments on proposed legislation or gubernatorial nominations pending before the committee. Joint Rule 304 governs the public hearing process.

A. Each person testifying shall announce his or her name, residence and affiliation prior to testifying. The person also shall either sign the sheet maintained by the committee clerk or otherwise provide that information to the committee clerk to place in the committee files.

B. Legislators and persons in the audience must be addressed by their title.

C. Pursuant to Joint Rule 307, all written materials presented to the committee must bear the name, address and affiliation, if applicable, of the presenter and the date presented. Persons submitting written materials shall provide the committee clerk with at least 20 copies.

D. All questions must be addressed through the chair. Pursuant to Joint Rule 304, the chair may limit testimony at public hearings as necessary for the orderly conduct of the hearing.

E. Committee members may question witnesses to clarify testimony and to elicit helpful and pertinent information. While probing questions may sometimes be appropriate, members shall show respect at all times for the witnesses and for one another. Members shall refrain from questioning that is argumentative, oppressive, repetitive or unnecessarily embarrassing to hearing participants. Advocacy and discussion among members are not appropriate at public hearings. A committee member who is the primary sponsor of a legislative document and any member who testifies for or against the legislative document ordinarily should refrain from questioning other witnesses.

F. Committee members and members of the public shall refrain from making or receiving phone calls during public hearings, and from using pagers during public hearings unless the pagers are placed in a non-audible mode.

G. Procedures for public hearings on nominations of gubernatorial appointments are governed by statute and the Joint Rules.

8. Procedures for work sessions. The purpose of a work session is to provide an opportunity for the committee members to deliberate on legislative documents and other matters pending before the committee.

A. All questions must be addressed through the chair.

B. Because work sessions are primarily for deliberation on bills and other committee matters by the committee members and for working with the committee analyst, members of the audience may not participate except at the invitation of the chair.

9. Reports. Joint Rule 310 governs committee reports. The committee shall report out every legislative document referred to it, in accordance with reporting deadlines established by the presiding officers and the Joint Rules. The report of the committee must include a recommendation.

A. Recommendations that may be made are:

Ought to Pass;
Ought to Pass as Amended;
Ought to Pass in New Draft;
Ought Not to Pass;
Refer to Another Committee; or
Leave to Withdraw.

Necessary fiscal notes must be incorporated into the committee report before the bill is reported out.

B. Except for Leave to Withdraw, the committee shall vote on all recommendations to be included in reports on a legislative document during a work session on that legislative document. Votes may not be taken after 10:30 p.m. or before 7:30 a.m. unless first authorized jointly by the presiding officers.

C. In accordance with Joint Rule 310(6) a sponsor may request Leave to Withdraw the sponsor's bill or resolve before it is advertised for a public hearing. The request may be granted only by the agreement of both chairs. When a request for Leave to Withdraw has been granted by the chairs, the bill or resolve is reported out as Leave to Withdraw.

D. When a vote is taken on a legislative document, the committee clerk shall record the vote. If all members are not present for the vote, the legislative document must be held in committee at least until the following periods have expired.

(1) If any member is absent from the State House and the Cross Building at the time of the vote, that member's vote may be registered with the clerk up until noon on the 2nd business day following the vote.

(2) If any member is absent from the committee at the time of the vote but present in the State House or the Cross Building, that member's vote may be registered with the clerk up until 5:00 p.m. on the day of the vote.

E. If the vote is not unanimous, more than one report is required. Majority and minority reports must be voted on in a work session in accordance with the Joint Rules.

F. A member may abstain from voting only if the member has a conflict of interest as described in Joint Rule 104.

G. The committee clerk shall prepare the committee jacket or jackets following the vote and obtain signatures from committee members as required.

H. The final version of all committee reports must be reviewed at a work session or otherwise distributed to all committee members. The committee shall ensure that all committee reports are available for review by the public no later than when the report is submitted to the Legislature.

I. After a committee vote, no substantive change may be made in the committee report unless motions to reconsider and to amend the report are approved at a committee work session.

J. All reports on any legislative document must be submitted to the Legislature at the same time and within applicable reporting deadlines established by the presiding officers.

10. Joint Referral of Bills: Bills with subject matter that overlap committee jurisdictions may be referred jointly to more than one committee. In those cases, Joint Rule 308(3) makes specific provisions for the conduct of public hearings and work sessions and for the reporting out of the bills.

11. Participation in the Budget Process: Joint Rule 314 requires each policy committee to appoint a subcommittee of at least 3 and not more than 5 of its members to serve as a liaison to the Joint Standing Committee on Appropriations and Financial Affairs in the consideration of the Governor's budget bill(s). Committee participation in development of budget legislation is governed by Joint Rule 314. Joint Rule 314 also requires that at the end of the session, the committee submit a list to the Appropriations Committee establishing its priority for committee bills that are placed on the Special Appropriations Table.

12. Procedures for review of gubernatorial nominations. The committee shall review gubernatorial nominations in accordance with the requirements of the Maine Constitution, Art. V, Part 1st, §8; the Maine Revised Statutes Title 3, Chapter 6; and Part 5 of the Joint Rules.

13. Use of the Committee Room: During the legislative session, Committee chairs and other committee members shall coordinate the use of the committee room with the committee clerk. At all other times, use of committee rooms must be coordinated through the Legislative Information Office.

14. Confidentiality. The committee shall protect confidential records in accordance with procedures set forth in Joint Rule 313 and freedom of access laws, the Maine Revised Statutes, Title 1, chapter 13, subchapter I.

Committee rules adopted by the Joint Standing Committee on

Date:

BY:

Senate Chair: _____ House Chair: _____

A copy of the adopted Committee Rules of Procedure must be posted in the committee room and be available for public review

IF THE COMMITTEE MAKES ANY CHANGES TO THESE RULES, THOSE CHANGES MUST BE IDENTIFIED AND PRESENTED TO THE PRESIDING OFFICERS.

PROPOSED CHANGES?
___ No

___ Yes

IF YES, REVIEWED AND AGREED TO BY:

_____ Date: _____
President of the Senate

_____ Date: _____
Speaker of the House

MEMORANDUM

To: Members, Health and Human Services Committee
From: Jane Orbeton, OPLA
Date: October 18, 2012
Re: Quick Facts on Medicaid, 2012

MEDICAID and MAINECARE, the quick facts:

The partnership

The Medicaid program is a federal-state partnership, governed by federal law and regulations and administered by each participating state in accordance with a State Plan approved by the Centers for Medicare and Medicaid Services in the US DHHS prior to implementation by the state. The Medicaid program is established in Title 22 of the Maine Statutes and is named the **MaineCare program.** Services are provided under an approved **State Plan** and under **5 waivers** that provide Maine with flexibility to provide services in a manner different from the State Plan requirements to populations named in the waivers: childless adults, persons with HIV, persons who have disabilities or who are elderly and persons with intellectual disabilities, autistic disorders or physical disabilities.

Federal financial participation

The federal-state partnership carries into financing of the Medicaid program. For the MaineCare program in 2012 the federal share for Medicaid services (referred to as federal financial participation or FFP) for federal fiscal year 2012 is 63.27% and for federal fiscal year 2013 in 62.57%. The state share is the remainder, 36.73% for 2012 and 37.43% for 2013. The federal share for the MaineCare program for administrative costs, as opposed to Medicaid services, is 50% and the state share is 50%.

Medicaid services

Services designated by federal law or regulation as mandatory

Inpatient and outpatient hospital services and physicians, nursing facilities, prescription drugs, behavioral health, nurse mid-wives and nurse practitioners, federally qualified health centers, clinical labs and x-rays, home health, transportation and comprehensive children's services.

Services designated by federal law or regulation as optional services

Diagnostic and screening services, speech therapy, occupational therapy, hearing, eye care, rehabilitation, hospice and personal care services.

342,431 MaineCare members served from July 2011 through June 2012

241,404	Traditional Medicaid
15,838	Children's CHIP
27,847	Parents and caretaker relatives
13,029	Childless adults (noncategorical adults, also known as "noncats")
44,313	MaineCare plus Drugs for the Elderly and MaineRxPlus

MaineCare expenditures from July 2011 through June 2012

Total expenditures: State General Fund: $769,774,525, Federal Funds: $1,472,100,614

Expenses by provider types: hospitals 29%, waiver services 14%, nursing facilities 13%, private non-medical institutions 7%, behavioral health 6%, physicians 5%, all other 26%.

Top clinical conditions: mental health, neurological disorders, dementias, signs and symptoms and prevention, gastrointestinal disorders, pregnancy and deliveries and newborns.

MEMORANDUM

To: Members, Health and Human Services Committee
From: Jane Orbeton, OPLA
Date: October 16, 2012
Re: Quick Facts on Medicare, 2012

MEDICARE, the quick facts:
The Medicare program is a 100% federal program designed to serve the elderly and permanently disabled. Federal law and regulation govern Medicare. In 2011 there were 49 million beneficiaries total nationwide. Of the beneficiaries, 83% are over 65 years of age and 17% of are persons with permanent disabilities who are age 65 and younger. The permanent disabilities may be physical, mental or developmental, or a diagnosis of AIDS.

- **Medicare Part A** pays for inpatient hospital services, skilled nursing care, hospice care, home health services
    - Accounts for 31% of benefit spending
    - Financed mainly by 2.9% payroll tax, paid half by employer and half by employee, or by premiums of $451/mo
    - Cost sharing through a deductible of $1156 in 2012 and co-pays

- **Medicare Part B** pays for physician, clinical lab services, outpatient hospital services, mental health, home health and other preventive and medically necessary services
    - Accounts for 18% of benefit spending
    - Financed in part by general revenues and premiums in 2012 of $99.90/mo to $319.70/mo depending on income level of beneficiary
    - Cost sharing through a deductible of $155 in 2012 and co-pays

- **Medicare Part C** is the Medicare Advantage program, a managed care option that provides Parts A, B and D benefits through a commercial plan chosen by the beneficiary
    - Accounts for 21% of benefit spending
    - Covers 25% of all beneficiaries
    - Financed by beneficiary premiums and other costs depending on the plan chosen

- **Medicare Part D** provides Medicare prescription drug benefits, an optional benefit in which 29 million beneficiaries are enrolled through a plan chosen by the beneficiary
    - Accounts for 12% of benefit spending
    - Financed in part by general revenue, premiums in 2012 of $39.36/mo to $96/mo depending on income level of beneficiary and state payments
    - Cost sharing through a deductible of $310 in 2012, co-pays, a coverage gap (the doughnut hole)

What health care services are not covered by Medicare? Medicare does not cover long-term care, routine dental or eye care, dentures, cosmetic surgery, acupuncture, hearing aids and exams for fitting them, and routine foot care.

MEMORANDUM

To: Members, Health and Human Services Committee
From: Anna Broome, OPLA
Date: August, 2012
Re: Maine Health Data Organization, 2012

Maine Health Data Organization, Title 22 Maine Revised Statutes, chapter 1683
The Maine Health Data Organization (MHDO) was established in 1996 as an independent executive agency to collect clinical and financial health care information. Its mission is to create and maintain a comprehensive health information database that is used to improve the health of Maine citizens. The MHDO maintains two websites, its home page and the HealthWeb of Maine.

- **What data does MHDO collect?** The MHDO has a number of data sets, including hospital inpatient, outpatient and emergency room data. Public hospital inpatient data collected includes age, length of stay, diagnoses and procedures, payer, disposition, demographics and race and ethnicity. In 2011, a new database was developed to replace separate inpatient and outpatient databases. The MHDO also collects hospital financial information, including structural and organizational information on Maine's hospitals such as acquisitions, consolidations, mergers, reorganizations and employment. The MHDO also collects commercial health care claims data from carriers, third-party administrators, CMS and Maine's Office of MaineCare Services.

- **Who has access to the database?** The MHDO responds to requests for data, provides data for the Maine Centers for Disease Control and initiatives such as Maine Kids Count, and provides data to consumers. In 2011, the MHDO released four quarters of hospital quality data to the Maine Quality Forum for use in publications and on their website; the MHDO collects the data and MQF analyses it and presents the information. In 2011, MHDO responded to 69 requests for data from 61 separate users. All data released protects patient confidentiality. Consumers can use the HealthWeb to check prices paid for procedures by provider and insurance carrier. Consumers and professionals can review information on hospital patient safety, rates of diseases, procedure utilization rates and costs of care.

- **What is the organizational structure?** The MHDO has a 10 member staff and is governed by a board of directors of 20 voting members and one non-voting member. 18 members of the board are appointed by the Governor: nine members represent providers; four represent consumers; three represent employers; and two represent third-party payers. In addition, the Executive Director of Dirigo Health and an employee of the Department of Health and Human Services appointed by the Commissioner are voting members. The Commissioner of Professional and Financial Regulation, or designee, is a non-voting member of the board. The MHDO staff are appointed by the board.

- **How is the MHDO funded?** The MHDO receives no general fund revenue. It is supported by assessments on health care providers, assessments on health care payers, and the sale of data. Assessments are based upon the difference between the authorized MHDO allocation for the fiscal year and the ending cash balance from the previous year. Maine hospitals and health carriers were each assessed at 38.5% of the authorized allocation. For 2011, funding consisted of $600,549 each from assessments to Maine hospitals and to health insurance carriers with health care premiums in Maine in excess of $500,000 for the year. Non-hospital health care providers and third party administrators were each assessed set at 11.5% of the authorized allocation. $179,385 was collected from these two groups. $175,863 was collected from fees for the costs of releasing the data. The MHDO also collected $13,500 in fines from providers for failure to pay the assessment fee or for missing or late data. As a result of legislation enacted by the 125th Legislature, retail drug stores were removed from the list of entities to be assessed; MHDO will redistribute assessments through rules.

MEMORANDUM

To: Members, Health and Human Services Committee
From: Anna Broome, OPLA
Date: October, 2012
Re: HealthInfoNet, 2012

HealthInfoNet
HealthInfoNet was formally launched in 2009 by PL 2009, c. 387, An Act Regarding the Transfer of Patient Health Care Information through an Electronic Health Information Exchange. HealthInfoNet (HIN) is an independent, private non-profit organization that operates the state's official health information exchange. It is funded by several sources including charitable foundations, Maine health care providers, and state and federal government grants.

- **What is a health information exchange?**

A health information exchange is an electronic data center of clinical information. It creates a single electronic patient health record accessed by participating providers in different locations who can share patient health information for treatment purposes. It includes prescriptions, allergies, and laboratory and test results. The goal is to provide safer, efficient and timely care with better coordination between caregivers, fewer medical errors, reduced health care costs, fewer repeat tests, and less paperwork.

- **What are the privacy and security protections of HIN?**
  - HIN is private and protected by a firewall. The network has no servers with a direct connection to the Internet.
  - Personal identifiable information and patient clinical data are encrypted.
  - The network is monitored at all times for attempted breach and misuse.
  - Third party audits are regularly conducted to ensure security measures are adequate.

- **How many health care practitioners and facilities participate in HIN?**

In the fall of 2012, 5,169 Maine clinicians and care staff had access to HIN, and 27 of Maine's 39 hospitals and 240 physician practices were connected. Over 180 ambulatory practices are connected. Over 1 million individuals in Maine had an HIN in mid-2012. HIN also automates laboratory reporting for certain illnesses and conditions, such as Lyme disease and food poisoning, to the Maine CDC.

- **Is a patient required to have their medical information in HIN?**

HIN has operated an "opt-out" policy since its inception so that the patient's medical information is not entered into the database if the patient opts out. In addition, PL 2011, chapters 347 and 373 legislate the ability for a patient to "opt-out" from the HIN. Participating health care practitioners or insurance companies may not deny treatment or insurance benefit from a patient who chooses not to participate in the health information exchange. A patient who opts out may choose to opt in at any time. Less than 1% of patients have opted out of HIN.

- **How is HIN governed?**

HIN is governed by a volunteer stakeholder Board of Directors. The board includes individuals representing business, healthcare providers, healthcare payers, consumers, and state government. Leadership and the board consulted with expert committees on consumer issues, professional practice, regional extension and technology.

MEMORANDUM

To: Members, Health and Human Services Committee
From: Jane Orbeton, OPLA
Date: October 23, 2012
Re: Maine Quality Forum and Maine Quality Forum Advisory Council

Maine Quality Forum and Maine Quality Forum Advisory Council
The Maine Quality Forum (MQF) and the Maine Quality Forum Advisory Council (MQFAC) were established in 2003 as a part of the original Dirigo Health law. The forum and advisory council exist within Dirigo Health. The governing statutes are Title 24-A, section 6951 and 6952.

Maine Quality Forum
The MQF, established in Title 24-A, section 6951, is a public agency governed by a board and functioning with the advice of the MQFAC. The duties of the Maine Quality Forum include the following:

- To collect and disseminate research regarding and to adopt measures to evaluate and compare health care quality and provider performance;
- To coordinate the collection of health care quality data, working with the Maine Health Data Organization and other entities, and to work with others to report health care quality information;
- To conduct educational campaigns and technology assessment reviews and make recommendations regarding certificate of need;
- To encourage and assist electronic technology; and
- To report annually on MQF, on health care-associated infections and on health provider-specific performance and to disseminate the reports to the public.

Maine Quality Forum Advisory Council
The MQFAC, established in Title 24-A, section 6952, is a 17-member public body formed to provide advice to the MQF. All members are appointed by the Governor after nominations and approval by the Health and Human Services Committee. Members represent consumers, employers, the State Employee Health Commission, health care providers, a private health plan and the MaineCare program. The duties of the MQFAC include the following:

- To convene providers to provide advice to the MQFAC and to serve as liaison to the provider group;
- To provide expertise in health care quality to assist the MQF board;
- To advise and support the MQF by establishing and monitoring with Dirigo Health an annual work plan for the MQF, providing guidance on the adoption of quality and performance measures, conducting public hearings and meetings and reviewing consumer education materials;
- To make recommendations regarding quality assurance and quality improvement priorities; and
- To serve as liaison between the MQF and other organizations working on health care quality.

MEMORANDUM

To: Members, Health and Human Services Committee
From: Anna Broome, OPLA
Date: October, 2012
Re: Supplementary Nutrition Assistance Program, 2012

Supplementary Nutrition Assistance Program
The Supplementary Nutrition Assistance Program (SNAP) was formerly known as the Food Stamp Program until the federal government changed the name in 2008. The food stamp program was first developed by the Secretary of Agriculture in the late 1930s and early 40s and then ended with an improved economy. A new pilot program was authorized under President Eisenhower and funded by President Kennedy; in 1964 the Food Stamp Act made the program permanent. The purpose of the program was to strengthen the agricultural economy and improve the nutrition of low-income households. The program has been amended at the federal level several times since 1964. In Maine, SNAP is known as the Food Supplement Program.

- **What are the federal and state responsibilities for SNAP?**

The SNAP program is established by the federal government. The USDA's Food and Nutrition Services is responsible for setting the parameters of the program, including eligibility standards, asset limits, allowable food types, and authorizing and monitoring of vendors. Maine's responsibilities, under the Department of Health and Human Services, Office of Family Independence, include implementation, eligibility determination by staff, and pursuit of overpayment and fraudulent claims.

- **Who is eligible for SNAP?**

Households must meet income tests unless all members are receiving TANF, SSI or general assistance. In general, gross monthly income is set at 130% of the federal poverty guidelines and net monthly income is set at 100% of the federal poverty level guidelines depending on the size of the household. Resources that are considered as income include bank accounts, real estate, personal property, some vehicles but the home, household goods and life insurance are not counted. Net income refers to gross income minus allowable deductions. Allowable deductions include a standard deduction (for non-food necessities such as housing, clothes, transportation, school supplies), 20% of earned income, actual costs of dependent care, child-support payments, shelter expenses greater than half of income, and medical expenses over $35 a month for people over 60 years of age. Benefits received under SNAP depend on the number of people in the household and monthly income after certain expenses are subtracted.

- **What can be purchased with SNAP?**

SNAP benefits can only be used to purchase food, plants and seeds. SNAP may not be used for non-food items, alcohol, tobacco, vitamins, medicines, foods eaten in a store, and hot foods ready to eat or food marketed to be heated in the store. States may not restrict food stamp use for certain foods (prohibiting junk food or requiring the purchase of vegetables, for example).

- **Are there other restrictions on SNAP recipients?**

Able-bodied adults between 16 and 60 years of age must register for work, accept an offer of suitable work and take part in employment or training programs. In addition, able-bodied adults aged 18 to 50 years of age without children or pregnant may only receive SNAP benefits for three months in a three year period unless working or in a workfare program.

- **Who pays for SNAP?**

The federal government pays 100% of the costs for SNAP benefits. In 2011, this amounted to $382 million in food supplement benefits in Maine. States are responsible for a portion of the administrative costs for the program. In the 2012-13 biennial budget, $2.1 million in General Fund and $3.4 million in Federal Funds was allocated in each year of the biennium for Food Supplement administrative costs.

- **Are there protections against fraud?**

SNAP Electronic Benefit Transfer (EBT) cards have reduced fraud to approximately 1% of the cost of the program. Public Law 2011, chapter 687 established a class D crime for unauthorized transfer or possession or a food supplement card. This does not prohibit a recipient of SNAP benefits from having a family member or friend collect groceries for them. The federal government prohibits trafficking and prohibits purchasing returnable beverage containers, dumping the contents and using deposit refunds to purchase items that are unable to be purchased with SNAP benefits. This rule will be incorporated by reference in Maine law when the rulemaking process is completed.

- **How are SNAP benefits issued?**

Since 2003, SNAP benefits are issued on a plastic debit card (an EBT card known as the Pine Tree Card). The EBT system allows a recipient to transfer their government benefits from a federal account to a retailer account to pay for products received using a PIN. EBT cards are also used for other benefits including WIC, TANF, ASPIRE support services and child care assistance. Restrictions on products purchased with SNAP or WIC benefits do not apply to other cash benefits such as TANF.

Federal SNAP Monthly Income Eligibility Limits for FY2012

	Monthly Income Limits (48 states not incl. AL and HA)	
Household Size	Gross (130% of fed. pov.)	Net (100% of fed. pov.)
1	$1,180	$908
2	$1,594	$1,226
3	$2,008	$1,545
4	$2,422	$1,863
5	$2,836	$2,181
6	$3,249	$2,500
7	$3,663	$2,818
8	$4,077	$3,136
Each additional member	$414	$319

Source: USDA, Food and Nutrition Service

MEMORANDUM

To: Members, Health and Human Services Committee
From: Jane Orbeton, OPLA
Date: August, 2012
Re: Long-term Care Redesign, 2012

Long-term Care System Redesign
The Maine long-term care system is beginning a process of redesign that is required by the enactment of Public Law 2011, chapter 422 and the passage of Resolve 2011, chapter 71.

- The law and resolve call for implementation of the Department of Health and Human Services (DHHS) LEAN Implementation Plan, as limited by existing resources, and consolidation of long-term care programs for in-home and community support and nursing facility services into one program with a single set of rules and intake system, coordinated eligibility criteria and qualifications and one budget line.
- The law and resolve require progress and feasibility reports to the Health and Human Services Committee early in 2012 and again by November 15, 2012.

- **What must the single unified long-term care program of services include?** The program must include a single system for intake and eligibility determination; periodic assessment of consumer need; transitional facilities and services; nursing facility diversion; reduced administrative costs; realistic rates consistent across types of care and services; for direct care workers a rate % for wages and benefits; analysis of equalization of rates; standards for training, service delivery structures, promotion of assistive technology, integration of skilled nursing and personal care; designation of qualified providers; investment in needed care and services; and financing options to encourage investment in residential and nursing facilities.

- **What initiatives are ongoing, as reported by DHHS?** These initiatives are ongoing: developing a statewide plan for long-term care services that ensures access to care in the least restrictive environment, maximizing federal funding opportunities, maximizing individualization and flexibility of plan of care, improving value and respect for direct care workers and designing an effective quality management strategy.

- **What initiatives are planned for implementation October 1, 2102?** These initiatives are scheduled for implementation by 10/1/12: consolidating personal care programs and consolidating consumer-directed service models.

- **What initiatives are planned for implementation October 1, 2013?** These initiatives are scheduled for implementation 10/1/13: consolidating 2 waivers for elders and adults with disabilities and consolidating state-funded programs for elders, adults with disabilities and adults with intellectual disabilities and independent services and supports.

- **What other initiatives are required?** The law and resolve also require DHHS, as limited by existing resources to; use a global budget for long-term care; balance the mix of services, with a goal of 50% of budget being used for home and community-based services; improve the financial and functional eligibility determination processes; maximize the ability of people to make informed choices; and develop a simple unified self-directed model with budget authority, surrogacy and options for persons using agency services.

MEMORANDUM

To: Members, Health and Human Services Committee
From: Jane Orbeton, OPLA
Date: November 13, 2012
Re: Children's Services, 2012

Children's Services
The Department of Health and Human Services (DHHS) provides a comprehensive array of children's services for children from birth through age 20.

- **Children's behavioral health and developmental services.** Children's behavioral health services programs in the Department of Health and Human Services (DHHS) serves children from birth through age 20 who have intellectual disabilities, autism spectrum disorders, serious emotional disturbances and mental illness. DHHS collaborates with families and contracted providers and agencies to provide case management, crisis services, outpatient services, medication management and home and community treatment services, respite care and residential services. Children with intellectual disabilities or autism spectrum disorders may also be eligible for rehabilitation services.

- **Child welfare services.** Child welfare services promote the safety and well-being of children, focusing first on the well-being of the child, respecting the right of parents to raise their own children and recognizing the child's need for a permanent family. DHHS receives reports of suspected child abuse and neglect, assesses the children's situations, provides services to preserve the family and prevent the need for removal of the children, takes custody of children when necessary and provides services when children are in state custody, works with kin and foster families to place children in need of removal and to reunify families and provides adoption and permanency guardianship services.

- **Home visiting services**. DHHS offers home visitation services to families with children from birth through age 5, providing home-based parent education and support and focusing on children in at-risk communities.

- **Head Start (age 3 through age 5) and Early Head Start (birth through age 2).** Head Start and Early Head Start provide comprehensive early education programs for children and their families, with the goal of having children ready for kindergarten and ready to succeed. In community-based agencies Head Start and Early Head Start provide education, child care, health and dental screenings, mental health support and family support services.

Child welfare ombudsman
The child welfare ombudsman program, administered through a contract between an outside agency and the Executive Department, provides ombudsman services with regard to child welfare services provided by DHHS. The ombudsman investigates and answers inquiries, advises and works toward agreements. The program provides annual reports to the Governor, Legislature and DHHS. See Title 22, section 4087-A.

MEMORANDUM

To: Members, Health and Human Services Committee
From: Jane Orbeton, OPLA
Date: November 9, 2012
Re: Adult Mental Health Services, 2012

Adult Mental Health Services
The Department of Health and Human Services (DHHS) provides mental health services for adults under the provisions of Title 34-B, chapter 3 directly by state employees and institutions or indirectly by community agencies, providers, facilities and hospitals under contracts with DHHS or through services to persons covered by MaineCare.

Consumer Council System of Maine
The Consumer Council System of Maine was established in 2008 to provide an effective, independent voice for consumers of adult mental health services. Local councils and a statewide council work to advise and assist DHHS, identify and respond to issues of concern to members, interact with DHHS and other agencies and submit an annual report. See 34-B, section 3611.

Voluntary mental health services

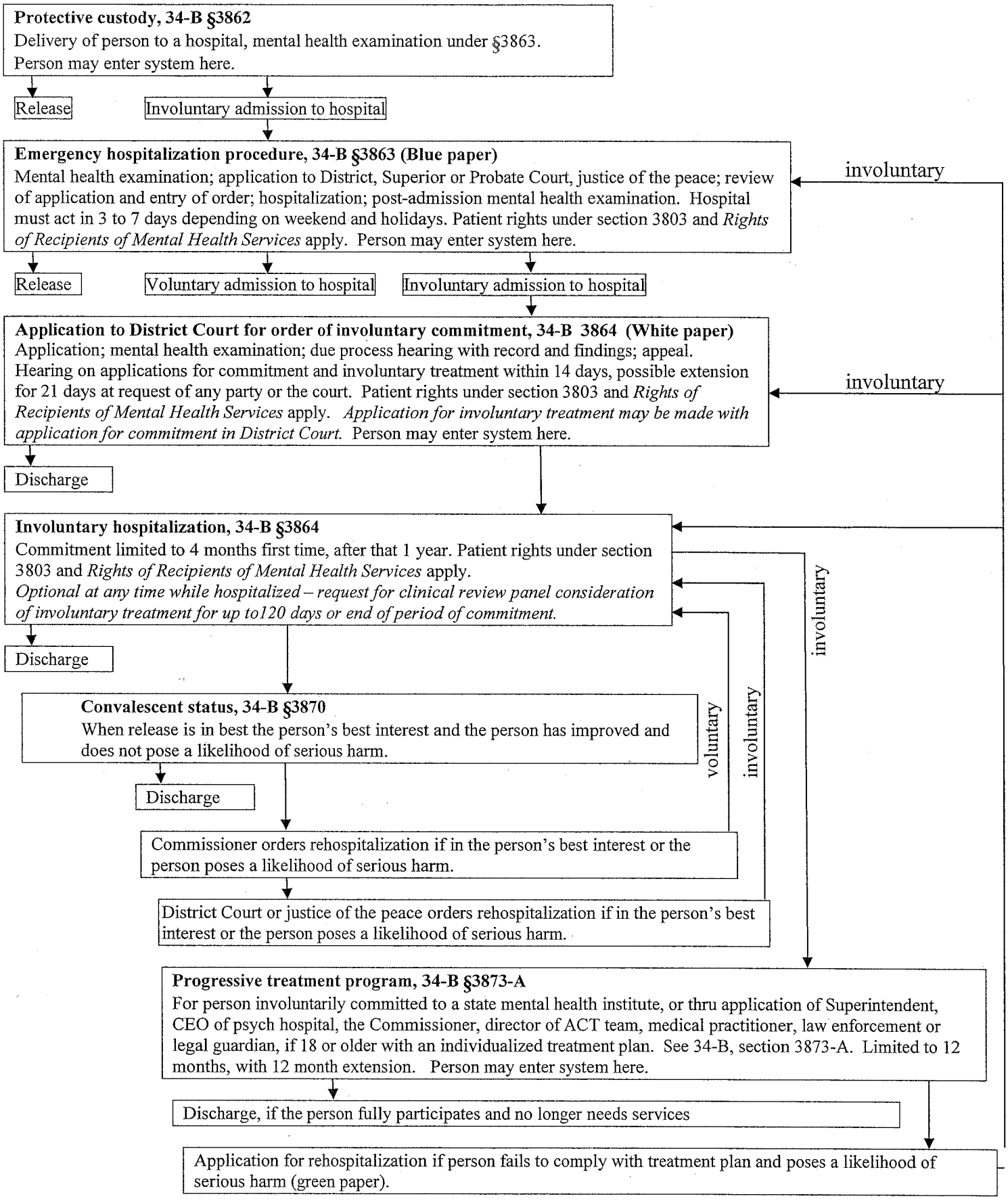
Community service networks are established by DHHS to coordinate and ensure mental health services for adults by mental health agencies and providers. **Residential adult mental health services** are provided in apartment and supportive living settings and in private nonmedical institutions (PNMI's). **Hospital inpatient mental health services** are provided at Dorothea Dix Psychiatric Institute (DDPC) in Bangor and Riverview Psychiatric Institute (RPC) in Augusta, and in community hospitals across the state.

Involuntary mental health services

Involuntary commitment services are provided in civil settings in community hospitals or DDPC or RPC for persons with serious mental illness who are a danger to themselves or others and in a forensic setting in RPC for persons ordered by a court to undergo examination or treatment in a hospital. Persons receiving mental health services on an involuntary basis are in the hospital in the custody of the Commissioner of DHHS until released by order of the court. The **progressive treatment program** serves persons who are involuntarily committed so that they may live and receive mental health services under a structured individualized treatment plan in the community either before or after hospitalization.

Community support system
DHHS is required by 34-B, section 3004 to develop mental health programs that promote and support a complex of mental health, rehabilitation, residential and support systems to ensure community integration and the maintenance of a decent quality of life for persons with chronic mental illness. DHHS must provide technical assistance, assess needs, monitor and evaluate service delivery, work with school systems on transition planning for students with chronic mental illness and report in December every other year to the Legislature's HHS Committee.

Flowchart of Involuntary Mental Health Commitment and Treatment Laws, 2012



MEMORANDUM

To: Members, Health and Human Services Committee
From: Anna Broome, OPLA
Date: November, 2012
Re: Prescription Monitoring Program, 2012

Prescription Monitoring Program
The Prescription Monitoring Program (PMP) was established in 2003 to detect and prevent substance abuse. The PMP is a database of all transactions for schedule II, III and IV controlled substances dispensed in Maine. 41 states have a fully operational PMP. In Maine, the database is available online to prescribers and dispensers. Registered users of the database can log on to the PMP website to look up their patients online. Clinicians and prescribers can use the PMP to check the history of a new patient and to monitor on-going treatment as well as a self-query to examine prescribing practices. Dispensers provide information on the dispensing of controlled substances through prescriptions within 7 days of dispensing although the PMP is currently developing a rule to allow for this data to be provided in real time. The PMP is funded by grant funding and it received another two years of grant funding from the Department of Justice starting October 1st, 2012.

Utilization of the PMP
Registration in the PMP by prescribers has been steadily increasing. Just over 30% of prescribers were registered in February 2011 and just over 50% were registered by August 2012. In addition, the number of reports requested from the PMP has increased from 16,476 for the third quarter of 2010 to 38,456 for the second quarter of 2012. PL 2011, c. 477 requires 90% of prescribers to be registered with the PMP by January 1, 2014 or all registration will be mandatory.

Confidentiality of PMP information
PMP information is confidential and is not a public record. Those with access to PMP information:

- Prescribers, or staff members, when the information relates to a patient under their care.
- Dispensers, when the information relates to a customer seeking to have a prescription filled.
- Patients, when the information relates to the patient.
- The executive director or board investigator of the state boards of licensure, e.g. dentistry, medicine, osteopathy, nursing, as required for an investigation, with reasonable cause.
- Personnel of the vendor or contractor as necessary for maintaining the PMP's electronic system.
- The Office of the Chief Medical Examiner for conducting an investigation into the cause, manner and circumstances of a death in a medical examiner's case.
- The office administering MaineCare to manage the care of members, monitoring the purchase of controlled substances by members and avoiding duplicate dispensing of controlled substances.

Review of PMP information
The Office of Substance Abuse (OSA) establishes acceptable threshold levels of controlled substances. The OSA and the PMP review the information collected in the database to determine questionable activity by patients and prescribers. A prescriber that prescribes levels of controlled substances that are outside of the norm in their field may be reviewed and disciplined by their relevant professional board. A patient may be determined to surpass threshold levels if the patient's file shows a high number of prescribers in a short time, a high number of doses in a short time, overlapping days supply, more than one pharmacy on the same day and more than one out of state provider for the same patient during a short time period. When a patient surpasses the threshold levels established by the OSA, the OSA automatically notifies the prescribers and the dispensers with the relevant information through an established letter of notification. Prescribers are encouraged to work with patients that are identified as exceeding threshold levels.

MEMORANDUM

To: Members, Health and Human Services Committee
From: Jane Orbeton, OPLA
Date: July, 2012
Re: Maine Medical Use of Marijuana, 2012

Maine Medical Use of Marijuana, Title 22 Maine Revised Statutes, chapter 558-C
Please note: Maine law governs Maine law enforcement and Maine courts but has no effect on federal law enforcement or federal courts. Under the Maine medical use of marijuana law a qualifying patient who has a physician's certificate may possess up to 2 ½ ounces of prepared marijuana. The patient may register with the Maine Medical Marijuana Program in the Department of Health and Human Services (DHHS). The law does not specify where the patient must obtain marijuana.

- **What medical conditions or diseases qualify a patient?** To qualify as a patient a person must have one of the medical conditions or diseases specifically listed in the law. A patient must have a debilitating medical condition, which is defined as cancer, glaucoma, HIV, AIDS, hepatitis C, ALS, Crohn's disease, agitation of Alzheimer's, nail-patella; a chronic or debilitating disease or medical condition that produces intractable pain that is nonresponsive to treatment for 6 months; or a chronic or debilitating disease or medical condition that produces cachexia or wasting syndrome, severe nausea, seizures or severe or persistent muscle spasms. The list is subject to change by DHHS through the rulemaking process.

- **What marijuana is allowed?** A qualifying patient may possess up to 6 mature flowering plants, up to 2 ½ ounces of prepared marijuana (dried leaves and flowers and tinctures, ointments and other preparations) and incidental marijuana (nonflowering marijuana, seeds, stalks and roots). A qualifying patient may cultivate or may designate a caregiver or dispensary to cultivate. The limits for a caregiver or a dispensary are the same, based on number of patients designating the caregiver or dispensary, and are subject to a cumulative total of 6 mature flowering plants per patient.

- **Who registers with DHHS?** A qualifying patient who has a physician's certificate may register but is not required to do so. A caregiver who has been designated to cultivate marijuana for a qualifying patient must register unless one of the family or household exceptions applies. The principal officers, board members and employees of registered dispensaries and hospice and nursing facilities that are designated caregivers for patients must register.

- **What is the role of a dispensary?** DHHS has selected 8 nonprofit medical marijuana dispensaries, one for each public health region in the state. Dispensaries may provide marijuana only to registered qualifying patients who have designated the dispensary to provide marijuana and the patients' registered caregivers. Dispensaries may assist registered qualifying patients with medical use and the administration of marijuana. Dispensaries must grow their own marijuana in enclosed locked facilities. They may not purchase marijuana. Dispensaries that prepare food or drink containing marijuana for medical use must be licensed to prepare and sell food. Dispensaries are subject to regulation by DHHS, inspection to ensure compliance with the law and reasonable land use regulation by municipalities.

MEMORANDUM

To: Members, Health and Human Services Committee
From: Jane Orbeton, OPLA
Date: August, 2012
Re: Elderly Low-cost Drug Program, 2012

Elderly Low-cost Drug Program
The Maine Elderly Low-cost Drug program, referred to as the DEL program or DEL, was established in 1975 with the enactment of Title 22, chapter 101. The DEL program provides discounted drugs, medications and medical supplies to adults with disabilities and to adults age 62 and over.

What does the DEL program do? DEL provides state-funded assistance to low-income persons for the purchase of prescription and nonprescription drugs, medications and medical supplies from drug manufacturers that participate in the program and pay rebates to the Department of Health and Human Services. Enrollees must be adults, residents of the State and either disabled under social security standards or age 62 and over.

Who is eligible for the DEL program? Income eligibility is calculated by reference to the federal poverty level (FPL), which in 2011 was $11,170 for a single person and $15,130 for a family of 2 persons.

- Eligibility for the basic and supplemental components of the program is 185% FPL, which is $20,664 for a family of 1 person and $27,990 for a family of 2 persons.
- Enrollment is also available to persons with incomes 25% higher than 185% FPL levels if the person or family spends 40% or more of its income on unreimbursed direct medical expenses for prescription drugs and medications.
- Eligibility for the basic and supplemental components of the program is also available to persons who are eligible for both MaineCare and Medicare Part D drug benefits.

- **What are the DEL basic component benefits?** In the basic component enrollees pay for brand name drugs and medications $2 plus 20% of each drug, medication or medical supply and for generic drugs and medications they pay $2 plus 20% of the drug or medication. Basic component drugs, medications and medical supplies area limited to the treatment of cardiac conditions, high blood pressure, diabetes, arthritis, anticoagulation, hyperlipidemia, osteoporosis, chronic obstructive pulmonary disease, asthma, incontinence, thyroid disease, glaucoma, parkinson's disease, multiple sclerosis and amyotropic lateral sclerosis.

- **What are the DEL supplemental component benefits?** In the supplemental component enrollees pay the cost of the drug, medication or medical supply to DEL minus $2

- **What are the DEL catastrophic component benefits?** In the catastrophic component enrollees who have paid above a threshold amount established by the Commissioner of Health and Human Services pay the 20% of the cost of the drug, medication or medical supply plus $2.

- **How is the DEL program related to Medicare Part D?** For enrollees who are eligible for Medicare Part D the DEL program may enroll them in a Medicare Part D plan and may provide emergency drug coverage and assistance with Medicare Part D premiums, cost-sharing and cost of drugs.

MEMORANDUM

To: Members, Health and Human Services Committee
From: Jane Orbeton, OPLA
Date: October 18, 2012
Re: Wild Mushroom Harvesting Certification, 2012

Wild Mushroom Harvesting Certification

The 125th Legislature was first ventured into the training and certification of commercial wild mushroom harvesters, brokers and sellers in 2011 and then amended the law in 2012. The Legislature was motivated by concern for public health and the safety of the food supply. Further motivation came from the serious and near fatal poisoning in 2010 of 2 Portland restaurant chefs who had purchased wild mushrooms from harvesters who came to the chefs' kitchens.

Maine Wild Mushroom Harvesting Certification Program

In the Maine Revised Statutes, Title 22, section 2175, the Maine Wild Mushroom Harvesting Certification Program is established, a registry is set up in the Department of Health and Human Services, an advisory committee is established, and the requirements of the program, its fees and rules are set forth.

Training programs. The law requires DHHS to approve wild mushroom training programs in accordance with the recommendations of the advisory committee.

Certification of commercial harvesters, brokers and sellers. The law requires DHHS to certify persons with appropriate training in mushroom harvesting, brokering and selling to sell, transfer or otherwise deliver wild mushrooms within the state. Certification lasts for 5 years. DHHS is required to maintain a registry of persons who apply for certification and persons who are certified by DHHS.

Advisory Committee. The law provides for an advisory committee of chefs and experts in environmental health, agriculture, mycology, poison control, health inspection, the restaurant industry, wholesale food distribution and sale, health inspection and mushroom harvesting and brokering. The advisory committee is charged with advising the Commissioner of DHHS regarding training programs and certification of trainers and harvesters, brokers and sellers. Advisory committee members serve as volunteers and are required to meet as needed but at least once per year.

Fees. DHHS is charged with establishing by rule a fee schedule, although the fee may not exceed $20. Fees collected under the program are required to be used in the health inspection program.

Rules. The law authorizes DHHS to adopt rules to implement the statute. The rules are designated as routine technical rules.

MEMORANDUM

To: Members, Health and Human Services Committee
From: Anna Broome, OPLA
Date: November, 2012
Re: Public Health Infrastructure and Healthy Maine Partnerships, 2012

Public Health Infrastructure

The Maine Center for Disease Control and Prevention (CDC) is Maine's public health agency. The state's emerging public health infrastructure is under the CDC. In 2005, the 40-member Public Health Work Group (PHWG) was convened to develop a more coordinated system for public health across the state. The 2007 PHWG report to the Legislature was enacted in 2009. That legislation included the Public Health Infrastructure to coordinate and streamline CDC contracts with community-based public health organizations. There are nine DHHS districts – eight geographical and one tribal district (enacted in 2011) that covers all tribal members. Each district has a District coordinating council for public health. The Statewide Coordinating Council (a successor to the PHWG) is a representative body of public health stakeholders that assists the Maine CDC on policy issues related to public health infrastructure, system assessment and performance and national accreditation.

Healthy Maine Partnerships

At the local level, Healthy Maine Partnerships (HMPs) carry out the programs of the districts through multiple contracts. There are 26 HMPs and 1 tribal district who work with multiple community partners as well as school districts. The goals of the HMPs are:

- Ensure that Maine has the lowest smoking rate in the nation.
- Prevent the development and progression of obesity, substance abuse, and chronic diseases related to, or affected by, tobacco use.
- Improve the capacity of municipalities and schools to provide health promotion, prevention, education, and self-management of health.
- Develop and strengthen local capacity to deliver essential public health services across the state.

HMPs are funded with Fund for a Healthy Maine (FHM) money which resulted from the tobacco master settlement. In line with the above goals, the majority of funding focuses on tobacco prevention, physical activity, nutrition, obesity, substance abuse, chronic disease prevention, coordinated school health and childhood lead poisoning. HMPs also perform community public health assessments in their local areas. Funding is awarded through an RFP process. The Maine CDC monitors the work of the HMPs to ensure it is completed and effective. The HMPs provide quarterly reports and data for assessing HMP strategies and the CDC makes site visits. Depending on performance, the CDC can award an HMP contract to the prior community agency or to a different agency.

MEMORANDUM

To: Members, Health and Human Services Committee
From: Anna Broome, OPLA
Date: October, 2012
Re: General Assistance, 2012

General Assistance
General Assistance (GA) is a program of last resort administered by the municipalities for the immediate assistance to people who cannot provide the basic necessities for themselves or their families.

- **Who qualifies for general assistance?**

GA assists people who cannot pay their basic expenses. The applicant must provide information necessary to determine eligibility. The period of eligibility is one month although the person may reapply at the end of that period. The applicant may also apply and qualify for emergency assistance within 24 hours if the administrator determines that the applicant is in an emergency situation and is likely to be eligible for assistance after full verification. "Emergency" means that the applicant is in a life-threatening situation or a situation in which the situation could pose a threat to the health or safety of the person. A person may become ineligible for a period of time if they provide false information, do not make a good faith effort to secure a potential income source, or if they violate a work-related rule without just cause, such as refusing to register for work or accept a suitable job offer.

- **What is the responsibility of a municipality?**

Municipalities are responsible for supporting any eligible resident of that municipality. "Resident" is defined in Title 22, section 4307 as "a person who is physically present in a municipality with the intention of remaining in that municipality to maintain or establish a home and who has no other residence". If a person is not a resident of any municipality, the municipality where the person first applies is responsible for support until a new residence is established. Municipalities may establish standards of eligibility, in addition to need, including maximum levels of assistance. However, municipalities may not establish durational residency requirements or move an applicant to a different municipality unless they are providing financial assistance and the applicant requests relocation. Procedures are established through DHHS and the court system to settle disputes between municipalities. DHHS releases information to municipalities that relates to eligibility. Title 22, section 4304 requires each municipality to have a GA office or designated place for a person to apply for GA. Two or more municipalities may combine to establish a district office provided that the office is accessible by a toll-free telephone call from any part of the municipalities that it serves.

- **What can general assistance be used for?**

GA provides vouchers to pay for "basic necessities", a term defined in Title 22, section 4301, subsection 1 to include food, clothing, shelter, fuel, electricity, nonelective medical services recommended by a physician, nonprescription drugs, telephone if necessary for medical reasons, and any other commodity or service determined necessary by the municipal ordinance or in Title 22, chapter 1161.

- **How is general assistance funded?**

The state pays 50% of the costs of GA expenses except when the costs to the town in any fiscal year are in excess of .0003 of the municipality's valuation. For municipalities that exceed the valuation threshold, DHHS reimburses at the 90% of those costs except that PL 2011, c. 655, Part R-3 reduced that reimbursement rate to 85% for July 1, 2012 to June 30, 2013. Municipalities pay the administrative costs of the GA program.

MEMORANDUM

To: Members, Health and Human Services Committee
From: Jane Orbeton, OPLA
Date: October 26, 2012

Re: Durational Residency Requirements for General Assistance, Temporary Assistance for Needy Families (TANF) and Medicaid/MaineCare

Having reviewed court cases on durational residency requirements, my opinion is that it is not possible to draft a durational residency requirement for general assistance, Temporary Assistance for Needy Families or Medicaid/MaineCare that would survive a challenge in court. It is my opinion that a durational residency requirement for general assistance, TANF and Medicaid/MaineCare would violate the United States Constitution. For Medicaid/MaineCare it would also violate federal Medicaid law.

Legal standard for durational residency requirements

The US Supreme Court has held that a durational residency requirement infringes upon the right to travel guaranteed by the 14th Amendment and the equal protection clause of the 14th Amendment to the US Constitution by classifying residents according to length of residency.

- The first step in judging the legality of a durational residency requirement is judging whether it results in a severe deprivation of a necessity of life.
- If a durational residency requirement deprives people of basic necessities of life, which the courts have articulated as health care, food or shelter, the requirement may be legal if it is rationally related to achieving a compelling state interest that cannot be achieved by a narrower law. The US Supreme Court articulated this test in *Shapiro v. Thompson*, 394 US 618 (1969), and *Memorial Hospital v. Maricopa County*, 415 US 250 (1974). The Ninth Circuit Court of Appeals articulated the test in *Saenz v. Roe*, 9th Circuit Court of Appeals, No. 98-97 (5/17/99) and the First Circuit in *Cole v. Housing Authority of City of Newport* in 435 F.2d 807 (1970).

Application of the standard to general assistance, TANF and Medicaid/MaineCare

- General assistance, TANF and Medicaid/MaineCare provide for basic necessities of life, so that a durational residency requirement is categorized as causing a severe deprivation and is judged by whether it is rationally related to achieving a compelling state interest that cannot be achieved by a narrower law.
- The following state interests, cited by legislatures as the reasons for durational residency laws, have failed the compelling state interest test when challenged in court:
    - discouraging people from moving in;
    - protecting the public budget;
    - planning the welfare budget;
    - providing a test for residency;
    - minimizing fraud;
    - maintaining public support for public services; and
    - encouraging employment.

MEMORANDUM

To: Members, Health and Human Services Committee
From: Jane Orbeton, OPLA
Date: October 24, 2012
Re: Access to Vital Records, 2012

Access to Vital Records
The Office of Data, Research and Vital Statistics and the offices of the clerks in Maine's municipalities provide access to vital records that include births, deaths, marriages and fetal deaths. The Office of Data, Research and Vital Statistics (ODRVS) is located within the Maine Department of Health and Human Services Maine Center for Disease Control and Prevention, Division of Public Health Systems.

- In addition to birth, death, marriage and fetal death information the ODRVS maintains vital registration services for acknowledgements of paternity, corrections to vital records and delayed registration, divorces, court determinations of legal name changes on birth records, preparation of new birth certificates, the adoption reunion registry and the domestic partner registry.
- Maine laws governing access to vital records are set forth in Title 22, chapters 701, 703, 705 and 707.

State Registrar of Vital Statistics
The Commissioner of Health and Human Services is required by Title 22, section 2701 to appoint the State Registrar of Vital Statistics who is responsible for receiving and preserving vital records, overseeing persons who have vital records duties, providing training, forms and instructions and monitoring the accuracy, completeness and validity of vital records information.

Municipal clerks
Municipal clerks are required by Title 22, section 2702 to keep chronological records of live births, deaths, marriages and fetal deaths that occur in their municipalities and that are reported to the clerks. The State Registrar of Vital Statistics requires reporting in certain formats and within certain timeframes.

Disclosure of vital records
Vital records are protected from open public view and state law controls when certified and noncertified copies are available. In general noncertified copies are for births more than 75 years ago, fetal deaths more than 50 years ago and marriages and domestic partnerships more than 50 years ago. The person named in the record, spouses and registered domestic partners, parents, descendants, legal custodians, guardians and authorized representatives and genealogical researchers have limited rights to inspect and obtain copies of records. See Title 22, section 2706.

Penalties for violations of the law
Title 22, section 2708 imposes Class D and E penalties for falsifying information, providing false information, altering a certificate or certified copy, hindering an investigation by the State Registrar of Vital Statistics, refusing to provide information when required by law to do so.

MEMORANDUM

To: Members, Health and Human Services Committee
From: Jane Orbeton, OPLA
Date: August, 2012
Re: Sentinel Events, 2012

Maine Sentinel Events Reporting Law, Title 22 Maine Revised Statutes, chapter 1684
The Maine sentinel events reporting law requires a health care facility to notify the Department of Health and Human Services (DHHS), Division of Licensing and Regulatory Services (DLRS) of the occurrence of a "sentinel event" by the next business day after the event occurs or the next business day after the facility discovers that the event occurred. Then within 45 days the facility must file a report with DLRS that identifies the sentinel event and provides thorough and credible root cause analysis. A facility may report a "near miss." A person who notifies DLRS, files a report in good faith or provides root cause analysis is immune from civil or criminal liability for that action.

- **What is a sentinel event?** A sentinel event is an unanticipated death or patient transfer to another facility, a major permanent loss of function unrelated to the patient's illness or underlying condition or proper treatment, an unanticipated death or loss of function in an infant or another serious and preventable event as identified by rule adopted by DHHS.

- **What health care facilities area required to report?** Health care facilities that are required to report include hospitals, the Dorothea Dix Psychiatric Center, the Riverview Psychiatric Center, ambulatory surgical centers, end stage renal disease facilities, intermediate care facilities for persons with intellectual disabilities and other facilities licensed by DLRS. "Health care facility" does not include a nursing facility or assisted living facility.

- **What information must be reported?** A health care facility in which a sentinel event occurs is required to notify DLRS within 1 business day, must then provide a more complete report within 45 days of the notification and must cooperate with DLRS in the fulfillment of its duties. The report must include root cause analysis, in which the facility's key leadership participates, including examination of human and other factors, underlying systems, risk points, potential improvements in systems or processes, responsibility for improvements and evaluation of improvements.

- **What information is confidential?** Notifications and reports by health care facilities and information developed by DLRS as a result of filings are confidential and privileged.

- **What are the duties of the Division of Licensing and Regulatory Services?** DLRS must review all notifications and reports and determine whether a sentinel event has occurred. DLRS may take other action within its authority, including an on-site visit. Only incidences of immediate jeopardy or compliance with Medicare requirements may be reported by DLRS to licensing personnel.

- **What reports are available to the Legislature, health care facilities and the public?** By February 1 each year DLRS must provide a public report with summary data of the number and types of sentinel events, rates of change and other analyses and an outline of areas to be addressed for the upcoming year.

Index of Acronyms

A&V	Access and Visitation
A+A	Aid and Attendance
AAA	Area Agency on Aging
AAA Area	Agencies on Aging
AABD	Assistance for the Aged, Blind and Disabled
AAG	Assistant Attorney General
AAHSA	American Association of Homes and Services for the Aging
AAP	American Academy of Pediatrics
AAPHD	American Association of Public Health Dentistry
AAPM	American Association of Physicists in Medicine
AAROM	Active Assistive Range of Motion
AARP	American Association of Retired Persons
AAS	American Association of Suicidology
ABAWD	Able-Bodied Adults Without Dependents
ABI	Acquired Brain Injury
ABNM	American Board of Nuclear Medicine
ABO	Abortions
ABR	American Board of Radiology
AC	Before Meals
ACC	Automatic Cancellation Clause
ACC	Ambulatory Care Center
ACD	Automatic Cancellation Date
ACDD	Accreditation Council for Services to Persons with Developmental Disabilities
ACE	Active Corps of Executives
ACES #1	Automated Client Eligibility System
ACES #2	Adult and Child Emergency Services
ACF	Administration for Children and Families
ACHCA	American College of Health Care Administrators

ACIP	Advisory Committee on Immunization Practices
ACME	Automated Classification of Medical Entities
ACORWD	Advisory Commission of Radioactive Waste and Decommissioning
ACOS	American College of Surgeons
ACP	American College of Physicians
ACR	Adjusted Community Rate
ACR	American College of Radiology
ACR	Administrative Case Review
ACS	American Cancer Society
ACS	American College of Surgeons
ACT-UP	AIDS Activist Group
AD	Active Directory
ADA	American Dental Association
ADA	Americans with Disabilities Act
ADD	Attention Deficit Disorder
ADEF	Ambulatory Diabetes Education and Follow-up
ADHA	American Dental Hygienists Association
ADHD	Attention Deficit Hyperactivity Disorder
ADIOS	Automated Data Integration Operating System
ADL	Activities of Daily Living
ADO	Augusta District Office
ADO	Adoption
ADP	Automated Data Processing
ADR	Adverse Drug Reaction
ADR	Alternative Dispute resolution
ADS	Adult Day Services
ADW	Adults with Disability Waiver
AEA	Atomic Energy Act
AEC	Atomic Energy Commission
AFCARS	Adoption and Foster Care Analysis and Reporting System
AFCH	Adult Family Care Home
AFDC	Aid to Families with Dependent Children

Index of Acronyms

AFDO	Association of Food and Drug Officials
AFFM	A Family For Me
AFFT	Adoptive and Foster Family Training
AFH	Adult Foster Home
AFHHA	American Federation of Home Health Agencies
AFIX	Assessment, Follow-up, Incentive, Exchange
AFL-CIO	American Federation of Labor-Congress of Industrial Organizations
AFSP	American Foundation for Suicide Prevention
AG	Attorney General
AG	Assistance Group
Agency	State agency, office, board, commission or qasi-independent
AH	Administrative Hearing
AHA	American Heart Association
AHA	American Hospital Association
AHA	American Humane Association
AHCA	American Health Care Association
AHFSA	Association of Health Facility Survey Agencies
AIDS	Acquired Immunodeficiency Syndrome
AIDS	Autoimmune Deficiency Syndrome
AKA	Also known as
ALARA	As Low As Reasonably Achievable
ALF	Assisted Living Facilities
ALPHA	Alternative Living for Physically Handicapped Adults Waiver
ALU	Assisted Living Unit
AMA	American Medical Association
AMCHP	Association of Maternal Child Health Programs
AMH	Augusta Mental Health
AMHI	Augusta Mental Health Institute
AMHI	Augusta Mental Health Institute (now Riverview Psychiatric Center)
AMM	Application Maintenance
AMR	Adult Mentally Retarded
AMT	American Medical Technologists
AMWA	American Metropolitan Water Association
ANA	American Nurses Association
ANCI	American National Standards Institute
ANHA	American Nursing Home Association
ANSI	American National Standards Institute
ANTH	Anthrax
AOA	American Osteopathic Association
AOBR	American Osteopathic Board of Radiology
AOP	Acknowledgement of Paternity
AP	Associated Press
AP	Agency Promotion
AP	Absent Parent
AP	Accounts Payable
AP	Awaiting Placement (Medicaid)
APA	Administrative Procedures Act
APA	American Psychiatric Association
APC	Absent Parent Contribution (child support)
APD	Advanced Planning Document
APHA	American Pharmaceutical Association
APHA	American Public Health Association
APHSA	American Public Human Services Association
APRC	Awaiting Placement for Residential Care
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
APS	Adult Protective Services

Index of Acronyms

APTP	Authorization Prior to Provision
AR	Accounts Receivable
ARC	Aid to Retarded Citizens
ARC	AIDS-Related Complex
AROM	Active Range of Motion
ARRT	American Registry of Radiologic Technologists
ASA	Assessing Services Agency
ASC	Ambulatory Surgical Centers
ASCP	American Society of Clinical Pathologists
ASDWA	Association of State Drinking Water Administrators
ASHA	American Speech and Hearing Association
ASHRAE	American Society of Heating, Refrigerating and Air-Conditioning Engineers, Inc.
ASPEN	Automated Survey Processing Environment
ASPIRE	Additional Support for People in Retraining and Education
ASPIRE	Additional Support for Retraining and Employment
ASTD	American Society of Training and Development
ASTDD	Association of State and Territorial Dental Directors
ATP	Authorization to Participate – Monthly Food Stamp Register
ATU	Advanced Treatment Unit
AWP	Average Wholesale Price
B&B	Bed and Breakfast
BBA	Balanced Budget Act of 1997
BC	Birth Certificate
BC	Blue Cross
BC/BS	Blue Cross/Blue Shield (see also BLUES)
BCFS	Bureau of Child and Family Services
BCFS	Bureau of Child and Family Services
BCSN	Bureau of Children with Special Needs
BDO	Bangor District Office
BDP	Birth Defects Program
BDS	Department of Behavioral and Developmental Services (formerly DMHMRSAS)
BEAS	Bureau of Elder And Adult Services
BEAS	Bureau of Elder Adult Services
BEERS	Beneficiary Earnings Exchange Record System
BEIR	Biological Effects of Ionizing Radiations
BENDEX	Beneficiary and Earnings Data Exchange
Bene	Beneficiary
BEOG	Basic Education Opportunity Grant Program
BEST	Beneficiary State Tape
BF 19	Bright Future (provider forms)
BFI	Bureau of Family Independence
BH	Boarding Home
BHARF	Boarding Home Assessment referral forms
BHR	Bureau of Human Resources-DAFS
BI	Brain Injured
BI	Buy In Medicare
BIA	Bureau of Indian Affairs
Bid	Twice a day
Bidder	Any firm qualified to submit a proposal to an RFP
BIM	Bureau of Income Maintenance (now known as BFI)
BIMR	Benefit Issuance and Management Reporting
BIS	Bureau of Information Services
BISSC	Baking Industry Sanitation Standards Committee
BLM	Bureau of Land Management
BLS	Bureau of Labor Statistics - DOL
BLUES	Blue Cross/Blue Shield
BMH	Bureau of Mental Health

Index of Acronyms

BMHI	Bangor Mental Health Institute - BDS
BMHI	Bangor Mental Health Institute
BMR	Bureau of Mental Retardation - BDS
BMS	Bureau of Medical Services
BMSLC	Bureau of Medical Services, Division of Licensing and Certification
BMV	Bureau of Motor Vehicles
BNAS	Brunswick Naval Air Station
BOER	Bureau of Employee Relations - DAFS
BOH	Bureau of Health
BOH	Bureau of Health
BOHS	Bureau of Highway Safety - DOT
BOI	Bureau of Insurance – DP&FR
BON	Board of Nursing
bp	Blood Pressure
BP	Bureau of Purchases – DAFS (now Division of Purchases)
BRAP	Bridging Rental Assistance Program
BRFSS	Behavioral Risk Factor Surveillance System
BS	Blue Shield
BSM	Business Services Manager
BSU	Behavioral Stabilization Unit
Bth	Births
BULL	Mainframe which supports most DHS online programs
Buy-In	State system that pays Medicare premiums for eligible Medicaid recipients
BV	Birth Verification
C & T	Certification and Transmittal Form (HCFA-1539)
CA	Cancer or carcinoma
CA/N	Child Abuse and Neglect
CAAN	Child Abuse Action Network (formerly Child Sexual Abuse Committee)
CAB	Coronary Artery Bypass Graft
CAB	Community Advisory Board (Community Consent decree)

CACFP	Child and Adult Care Good Program
CAH	Critical Access Hospital
CAHC(F)	Consumers for Affordable Health Care (Foundation)
CAHPS	Consumer Assessments of Health Plan Study
CAP	Citizens Advisory Panel
CAP	College of American Pathologists
CAP	Community Action Program
CAPD	Continuous Ambulatory Peritoneal Dialysis
CASA	Clinical Assessment Software Application
CASA	Court Appointed Special Advocate
CASE	Computer Aided Software Engineering
CAT	Computerized Axial Tomography
CBA	Collective Bargaining Agreement
CBT	Computer Based Training
CBT/DBT	Family Psychoeducation, Cognitive Behavioral Therapy, Dialectical Behavioral Therapy and Family
CBTRUS	Central Brain Tumor Registry of the United States
CC	Children's Cabinet
CC	Cub Care
CC	Child Care
CC	Convalescent Center
CC	Cubic Centimeter
CC	Cost of Care
CCAC	Child Care Advisory Council
CCCP	Comprehensive Cancer Control Program
CCDF	Child Care Development Fund
CCDH	Center for Community Dental Health

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CCelsius or centigrade c (with line over it)	With
CCP	Critical Control Points
CCR	Central Client Registry
CCU	Coronary Care Unit
CD	Certificate of Deposit
CDA	Child Development Associate (Scholarships)
CDBG	Community Development Block Grant
CDC	Centers for Disease Control (and Prevention)
CDC	Centers for Disease Control
CDR	Claim Detail Report
CDRH	Center for Devices and Radiological Health
CDS	Child Development Services
CDT	Current Dental Terminology
CE	Categorically Eligible
CEI	Coastal Enterprises Inc.
CERCLA	Comprehensive Environmental response, Compensation, and Liability Act
Certifica-tion	Formal Federal process to assess that ACES is operational and meets or exceeds criteria
Certified Seed	Legally appropriate source of monies, intended to be used as seed (state share) for payments of Medicaid services
CEU	Continuing Education Unit
CF	Cystic Fibrosis
CFR	Code of Federal Regulations
CFS	Child and Family Services
CFSAN	Center for Food Safety and Applied Nutrition
CFSR	Child and Family Services Review
CHAP	Community Health Accreditation Program
CHC	Community Health Center

CHINS	Children In Need of Services
CHIP (SCHIP)	Child Health Insurance Program
CHIPS	Child Health Insurance Program (also SCHIPS - State CHIPS)
CHM	Campaign for a Healthy Maine
CHN	Community Health Nursing
CHN/PHN	Children with Special Health Needs/ Public Health Nursing
CHOW	Change of Ownership
CHP	Certified Health Physicist
CHP	Comprehensive Health Planner
CHSP	Congregate Housing Services Program
CIAT	Commissioner's Implementation Advisory Team
CIP	Community Intervention Programs
CIS	Changes in Scope
CLIA	Comprehensive Laboratory Improvement Act
CM/QA	Contract Monitor/Quality Assurance
CMC	Case Management Conference
CMH	Children's Mental Health
CMI	Case Mix Index
CMMC	Central Maine Medical Center
CMO	Case Management Officer
CMP	Civil Monetary Penalty
CMP	Central Maine Power Company
CMPW	Class Member Public Wards
CMR	Chemical Monitoring Reform
CMS	Center for Medicare and Medicaid Services
CMS	Claims Management System
CMS	Centers for Medicaid and Medicare Services
CMSA	Consolidated Metropolitan Statistical Area
CN	Categorically Needy
CNA	Certified Nurse's Assistant
CNA-M	Certification Nurses Aide – Modification Aide

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CNM	Certificate Nurse Midwife
CNS	Central Nervous System
CNS	Clinical Nurse Specialist
CO	Central Office
COA	Certificate of Authority
COA	Change of Address
COBOL	Common Business Oriented Language
COBRA	Consolidated Omnibus Budget Reconciliation Act
COC	Commission on Cancer
CODES	Crash Outcomes Data Evaluation System
COLA	Cost of Living Allowance
COMTEN	Acts as a converter, which provides local offices access to either of the mainframes at BIS
CON	Certificate of Need
Contract	Agreement between DHS and a successful Bidder
Contractor	Vendor/Provider
COP	Condition of Participation
COPD	Chronic Obstructive Pulmonary Disease
Core Cost	Costs covering the core tasks of CMS, including functional, hardware, software and training costs
COS	Category of Service
COT	Committee on Transition (interdepartmental committee working on
COV	Condition of Coverage
CP	Custodial Parent
CPA	Child Placing Agency
CPA	Conservation Priority Area
CPAS	Claims Processing Assessment System
CPC	Children's Policy Committee
CPI	Consumer Price Index
CPM	Critical Path Method
CPRs	Computerized Patient Records
CPS	Child Passenger Safety
CPS	Child Protective Services
CPS	Claims Processing System
CPSI	Center for Public Sector Innovation
CPT	Current Procedural Technology
CR	Classification Review
CR	Cost Reimbursement
CRBH	Cost Reimbursement Boarding Home
CRCPD	Conference of Radiation Control Program Directors
CRCPS	Canadian Royal College of Physicians and Surgeons
CREP	Conservation Reserve Enrollment Program
CRIPA	Civil Rights of Institutionalized Persons Act
CRM	Cancer Registrars of Maine
CRMA	Certified Residential Medication Aide
CRNA	Certified Registered Nurse Anesthetist
CRP	Conservation Reserve Program
CRT	Children's Review Team
CRU	Case Review Unit
CS	Central Supply
CS	Civil Service
CS	Child Support
CS	Children's Services
CS	Community Spouse
CSBG	Community Services Block Grant
CSC	Community Services Center
CSD	Community School District
CSD	Conversion Specification Document
CSGWPP	Comprehensive State Ground Water Protection Program
CSHM	Children with Special Health Needs
CSHP	Coordinated School Health Program
CSS	Community Service Centers
CST	Civil Support Team
CSTE	Council of State and Territorial Epidemiologists

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CSV	Cash Surrender Value (life insurance)
CT	Computed Tomography
CT DCKT#	Court Docket Number
CT DET	Court Determination
CTR	Certified Tumor Registry
CV	Cadiovascular
CVA	Cerebral Vascular Accident (Stroke)
CVAP	Crime Victims Assistance Program
CW	Child Welfare
CWA	Clean Water Act
CWAC	Child Welfare Advisory Committee
CWLA	Child Welfare League of America
CWS	Community Water System
CWSRF	Clean Water Act State Revolving Fund
CWTI	Child Welfare Training Institute
CZARA	Coastal Zone Act Reauthorization Amendments
D & C	Dilation and Curettage
D & E	Dilation and Evacuation
DAB	Deparment Appeals Board
DAC	Disabled Adult Children
DAFS	Dept of Administrative and Financial Services
DBA	Doing business as...
DBMS	Database Management System
DBP	Disinfection By-Products
DC	Death Certificate
DC	Disease Control
DCAA	Dental Care Analysis Area
DCCS	Division of Contracted Community Services
DCO	Dental Certificate Only
DCP	Diabetes Control Program
DCP	Direct Care price
DDP	Division of Data Processing
DDS	Disability Determination Services
DDT	Division of Diabetes Translation
DDU	Disability Determination Unit
Dea	Deaths
DEA	Drug Enforcement Agency (Federal or State)
DEEP	Driver Education and Evaluation Programs
DEHS	Downeast Health Services
DEL	Drugs for the Elderly (or Disabled Program)
DEL	Drugs for the Elderly and Disabled Program
Deliverable	Work/products produced by the Contractor
DEP	Department of Environmental Protection
DESI	Drug that is less than effective
DFSR	Division of Federal-State Relocation
DHCP	Dynamic Host Connection Protocol
DHE	Division of Health Engineering
DHHS	Department of Health and Human Services
DHRS	Diocesan Human Relations Services
DHS	Department of Human Services
DHSTI	DHS Training Institute
DIS	Detailed Implementation Schedule
DIV	Divorces
DM	Diabetes Mellitus
DMA	Dietary Managers Association
DME	Durable Medical Equipment
DMH	Division of Mental Health
DMHMRSAS (now BDS)	Dept of Mental Health & Retardation & Substance Abuse Services
DMQRP	Division of Mammography Quality and Radiation Programs
DMR	Division of Mental Retardation
DMV	Division of Motor Vehicles

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DNS	Domain Name Services
DO	Doctor of Osteopathy
DO	District Office
DOB	Date of Birth
DOC	Department of Corrections
DOD	Department of Defense and Veteran Affairs
DOD	Date of Death
DOE	Department of Energy
DOE	Department of Education
DOH	Date of Hire
DOH	Division of Oral Health
DOI	Department of Interior - Federal
DOJ	Department of Justice - Federal
DOL	Department of Labor – State or Federal
DOL	Department of Labor
DOM	Date of Marriage
DON	Director of Nursing
DOP	Division of Purchases
DOT	Date of Termination
DOT	Department of Transportation
DoTS	Division of Technology Services
DP	Distinct Part
DP	Data Processing
DPCP	Diabetes Prevention and Control Program
DPSR	Data Processing Service Request
DPSS	Division of Purchased Social Services
DRG	Diagnosis Elated Group
DROMBO	Division of Regional Office of Management & Budget Operations
DRS	Disqualified Recipient Subsystem (for Federal Food Stamps)
DSDP	Dental Services Development Program
DSER	Division of Support Enforcement and Recovery

DSH	Disproportionate Share Hospital
DSME	Diabetes Self-Management Education
DSMT	Diabetes Self-Management Training
DSS	Decision Support System
DSSP	Dental Services Subsidy Program
DT	Diphtheria, Tetanus
DTAP	Diphtheria, Tetanus, Pertussis
DUR	Drug Utilization Review
DVR	Division of Vocational Rehabilitation
DWB	Disabled Widow's Benefits
DWP	Days Waiting Placement
DWP	Drinking Water Program
DWSRF	Drinking Water State revolving Fund
E & L	Eating and Lodging
EA	Emergency Assistance
EAC	Estimated Acquisition Cost
EAP	Employee Assistance Program
EAP	Emergency Assistance Program
EBC	Electronic Birth Certificate
EBP	Evidence Based Practice
EBT	Electronic Benefit Transfer
EC	Extraordinary Circumstances
ECC	Early Childhood Caries
ECETF	Early Care and Education Task Force
ECOS	Environmental Council of the States
EDBC	Eligibility Determination and Budget Calculation
EDC	Electronic Death Certificate
EDI	Electronic Data Interface
Effective Date	Date contract is fully executed
EFT	Electronic Funds Transfer
EIC	Earned Income Credit
EIM	Elder of Independence of Maine
EIM	Elder Independence of Maine

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EIN	Employer Identification Number
EIP	Environmental Impact Statement
EIS	Enterprise Information System
EMC	Electronic Media Claims
EMF	Electro-Magnetic Field
EMMC	Eastern Maine Medical Center
EMMC	Eastern Maine Medical Center
EMPG	Emergency Management Performance Grant
EMS	Emergency Medical Services – Dept of Public Safety
EMTLA	Emergency Medical Treatment and Active Labor Act
Encounter Claim	Claim utilized by Managed Care Organizations
EOB	Explanation of Benefits
EOMB	Explanation of Medical Benefits or Explanation of Medicare Benefits
EPA	Environmental Protection Agency
EPCRA	Emergency Planning and Community Right-To-Know Act
EPI	Epidemiologist
EPSDT	Early Periodic Screening and Diagnostic Testing
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment services for children
ERS	Electronic Remittance Statement
ESE	Entrance Skin Exposure
ESRD	End Stage Renal Disease
Event	Any written or oral communication by the State's Administrator, Project Manager or any duly designated representative
EVS	Enumeration Verification System
FAMIS	Family Assistance Management Information System (now ACES)

FARS	Fatality Analysis Reporting System
FBI	Federal Bureau of Investigation
FBR	Federal Benefit Rate
FCA	Family Contract Amendment
FCC	Federal Communication Commission
FCS	Food and Consumer Service (now known as Food and Nutrition Services)
FD	Fetal Deaths
FDA	Food and Drug Administration
FDA	Family Development Account(s)
FDC	Family Day Care
FEE	Front End Eligibility Examination
FEMA	Federal Emergency Management Agency
FFDCA	Federal Food, Drug, and Cosmetic Act
FFP	Federal Financial Participation
FFP	Federal Financial Participation
FFTA	Foster Family-based Treatment Association
FFY	Federal Fiscal Year
FH	Fair Hearing
FH	Foster Home
FHA	Federal Housing Administration
FHM	Fund For a Healthy Maine
FI	Fiscal Intermediary
FIFO	First In First Out
FIFRA	Federal Insecticide, Fungicide, and Rodenticide Act
FIN	Financial & Budget
Final Acceptance	Acceptance of a completed project per RFP/Contract
FIPS	Federal Information Processing Standards
FIR	Fraud Investigation & Recovery
FIS	Family Independence Specialist

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FIU	Field Instruction Unit
FIU	Fraud Investigation Unit
FJA	Functional Job Analysis
FLRP	Federal Loan Repayment Program
FLSA	Fair Labor Standards Act
FMAP	Federal Medical Assistance Percentage
FmHA	Farmer's Home Administration
FMLA	Family Medical Leave Act
FMO	Fire Marshall's Office
FMR	Fluoride Mouth Rinse
FMS	Federal Monitoring Survey
FMV	Fair Market Value (property)
FNS	Food & Nutrition Services
FNS	Full Need Standard
FOF	Flow of Food
FOIA	Freedom of Information Act
FOSS	Federal Onsite and Support Survey
FPL	Federal Poverty Level
FPL	Federal Parent Locate
FPO	Financial Protection Orders
FQHC	Federally Qualified Health Center
FQHC /RHC	Federally Qualified Health Centers/ Regional Health Centers
FR	Federal Register
FRBH	Flat Rate Boarding Homes
FRL, FRLR	Free and Reduced Lunch Rate
FRM	Federal Reporting
FRMAC	Federal Radiological Monitoring and Assessment Center
FRS	Financial Resources Specialist
FS	Food Stamps
FSA	Farm Service Agency
FSA	Family Support Administration
FSCPE	Federal-State Cooperative population Estimates
FSCPP	Federal-State Cooperative Population Projections

FSD	Free Standing Day Habilitation
FSES	Fire Safety Evaluation System
FSIS	Food Safety Inspection Services
FSIU	Food Stamps Issuance Unit
FSUA	Full Standard Utility Allowance
FTE	Full Time Equivalent
FTE	Full Time Equivalent
FTP	File Transfer Protocol
FUL	Federal upper Limit
Function	Grouping of related activities aimed at accomplishing a major service
FUSRAP	Formerly Utilized Sites Remedial Action Program
FY	Fiscal Year – State - July 1 – June 30
GA	General Assistance
GA	General Assistance Program
GAAP	Generally Accepted Accounting Principles
GAL	Guardian ad Litem
GAO	General Accounting Office
GCOS	General Computer Operating System
GCOS	General Comprehensive Operating Supervisor
GCPF&S	Governor's Council on Physical Fitness and Sports
GD	Grant Diversion
GDM	Gestational Diabetes Mellitus
GED	General Equivalency Degree
GEOCOD E	Geographical Codes
GF	General Fund
GHS	Goold Health Services
GHS	Gould Health Systems
GI	Gastro-Intestinal (Upper) or (Lower) Tract
GIPRA	Government Improvement, Performance & Results Act (Federal)
GIS	Geographic Information System
GMP	Good Manufacturing Practices

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GMT	Greenwich Mean Time
GSA	Government Services Administration
GSD	General System Design
GSL	Guaranteed Student Loan Program
GTCC	Greater Than Class C Waste
GUI	Geographic User Interface
GWDR	Ground Water Disinfection Rule
GWPC	Ground Water Protection Council
HA	Housebound Allowance
HAA	Hospital Analysis Area
HACCP	Hazard Analysis Critical Control Point
HAZMAT	Hazardous Materials (DEP)
HBA	Health Benefits Advisor
HBC	Home Based Care
HBC	Home Based Care
HBM	Health Benefits Manager
HBO	Hyperbaric Oxygen Therapy
HCBS	Home and Community Based Services
HCC	Health Care Center
HCCA	Home Care Coordinating Agency
HCF	Health Care Facility
HCFA	Health Care Financing Administrative (Federal)
HCIS	HCFA Customer Information System
HCPCS	HCFA Common Procedure Coding System
HDR	High Dose Rate Remote Afterloader
HEAP	Home Energy Assistance Program
HEDIS	Health Plan Employer Data & Information Set®
Hep B-PF	Hepatitis B – Preservative Free
HEPA	High Efficiency Particulate Air filter
Hep-A	Hepatitis A Peds

HETL	Health and Environmental Testing Laboratory
HF	Healthy Families
HFS	Health Facility Specialist
HH	Head of Household
HHA	Home Health Agency
HHA	Home Health Assistant
HHA	Home Health Aide
HHCS	Home Health Care Services
HHS	U.S. Department of Health and Human Services
Hib	Haemophilus Influenza Type b
HIPAA	Health Insurance Portability & Accountability Act
HIPO	Health Insurance Premium Option
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
HLC	High Level Control
HLRB	Hospital Licensing Review Board
HLW	High Level Waste
HM2010	Healthy Maine 2010
HMAF	Handicapping Malocclusion Assessment Form
HMEP	Hazardous Materials Emergency Planning
HMO	Health Maintenance Organization
HMP	Health Maine Partnerships
HMP	Healthy Maine Prescriptions
HMP	Healthy Maine Prescription Program
HMPD	Health Maine Prescriptions for Persons with Disabilities
HMS	Health Management Systems
HO	Hearing Officer
HOME	Hoe Operating/Management Evaluation
HPS	Health Physics Society
HPSA	Health Professional Shortage Area
HR	Human Resources (Division)

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HRCHC	HealthReach Community Health Centers
HRP	Human Resource Profile
HRSA	Health Resources and Services Administration
HSA	Hospital Service Area
HSC	Health Services Consultant
HSS	Health Services Supervisor
HTML	Hypertext Markup Language
HTTP	Hypertext Transmission Protocol
HUD	Housing and Urban Development
HVAC	Heating Ventilation and Cooling
HVC	Home Visiting Coalition
HVL	Half Valve Layer
I & E	Information and Education
IACET	International Association of Continuing Education and Training
IADL	Instrumental Activities of Daily Living
IAEA	International Atomic Energy Agency
IAQ	Indoor Air Quality
IATF	Interagency Task Force (Homelessness)
IAU	Institutional Abuse Unit
IBM 3090-300S	Mainframe that runs NECSES and other DHS Programs
IC	Incapacitated
ICD	International Classification of Diseases
ICD-O	The International Classification of Diseases for Oncology
ICF	Intermediate Care Facility (Nursing Facility)
ICF/ MR-G	Intermediate Care Facility for people with mental retardation with group needs
ICF/ MR-N	Intermediate Care Facility for people with mental retardation with nursing needs
ICF\MR	Intermediate Care Facilities for the Mentally Retarded
ICM	Integrated Case Management
ICM	Integrated Case Management
ICMS	Islands Community Medical Services
ICPC	Interstate Compact on Placement of Children
ICRP	International Commission on Radiation Protection
ICU	Intensive Care Unit
IDC	Interdepartmental Council
IDR	Informal Dispute Resolution
IDS	Integrated Delivery System
IDT	Inter Disciplinary Team
IEVS	Income and Eligibility Verification System
IF&W	Inland Fisheries and Wildlife
IHP	Individual Habilitation Plan
IHS	Indian Health Service
IIK	Income-in-Kind
IIWO	Immediate Income Withholding Order
IJ	Immediate Jeopardy
IL	Independent Living
IMMPACT	Maine and New Hampshire Immunization Registry
IMU	Income Maintenance Unit
INS	Immigration and Naturalization Services
IOC	Inspection of Care
IOC	Internal Operations Committee
IOM	Institute of Medicine
IOSC	Individual Opportunity Service Contract
IP	Internet Protocol
IPA	Independent Public Accountant
IPP	Individual Program Plan
IPSI	Institute for Public Sector Innovation
IPV	Injected Polio Vaccine
IPV	Intentional Program Violation
IPX	Internet Work Packet Exchange

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IQCS	Integrated Quality Control System
IR	Investigations & Recovery
IRA	Individual Retirement Account
IRS	Internal Revenue Service (Federal)
IRWE	Impairment-Related Work Expenses
ISFSI	Independent Spent Fuel Storage Installation
ISP	Individual Service Plan
ISPB	Information Systems Policy Board
ISU	Information Systems Unit
ISW	Injury Surveillance Workgroup
ITOP	Induced Termination of Pregnancy
IUP	Intended Use Plan
IV & V	Independent Validation and Verification
IV-D	Support Enforcement/Title IV-D of the Social Security Act
IV-E Funding	Title IV-E of the Social Security Act (Federal): subsidizes foster care
IWI	Index of Watershed Indicators
IWO	Immediate Wage Withholding Order
JAD	Joint Application Development
JAIBG	Juvenile Accountability Incentive Block Grant
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JET	Job Exploration and Training
JETCC	Joint Environmental Training Coordinating Committee
JJAG	Juvenile Justice Advisory Committee
JOBS	Job Opportunities and Basic Skills
JR	Judicial Review
JTPA	Job Training Partnership Act
KI	Potassium, Iodide (elemental KI)

KSA	Knowledge, Skills and Abilities
KVDC	Kennebec Valley Dental Coalition
kVp	Kilo Volts Potential
L & C	Licensing and Certification
L/A	Living Arrangement
LAN	Local Area Network
LAT	Local Area Terminal Protocol
LBW	Low Birth Weight
LCN	Legal Change of Name
LCSW	Licensed Clinical Social Worker
LFA	Lead Federal Agency
LIRV	License Revocation
LLW	Low Level Waste
LMP	Last Normal Menstrual Period
LMSW	Licensed Master's of Social Work
LOC	Levels of Care
LOCUM TENENS	A Provider that substitutes for another provider
LOINC® Codes	Copyrighted code providing a set of universal names & ID Codes
LP	Legal Parent
LPC	Licensed Professional Counselor
LPI	Local Plumbing Inspector
LPN	Licensed Practical Nurse
LSAC	Licensed Substance Abuse Counselor
LSC	Life Safety Code
LSE	Licensed Site Evaluator
LSE	Legal Services for the Elderly
LSW	Licensed Social Worker
LTC	Long Term Care
LTCOP	Long-Term Care Ombudsman Program
LTFC	Long Term Foster Care
LTP	License Termination Plan
LTR	Lawful Temporary Resident
LWOP	Leave Without Pay
M & R	Medical & Remedial
MA	Metropolitan Area

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MA	Medical Assistance
MAAP	Maine Uniform Accounting and Auditing Practices for Community Agencies
MAC	Maximum Allowable Cost (Charge)
MAC	Medicaid Advisory Committee
MACWIS	Maine Automated Child Welfare Information System
MAFAP	Maine Association of Foster and Adoptive Parents
MAHPERD	Maine Association for Health, Physical, Education, Recreation and Dance
MAINE NET	System to enhance the clinical & administrative coordination of primary, acute and long-term care services
MAINE PrimeCare	Maine Primary Care Case Management Program
MAMHS	Maine Assoc. of Mental Health Services
MAP	orig. Medical Assistance Payments but now Medical Care - Payment to Providers
MAPA	Maine Administrative Procedure Act (APA)
MAPP	Maine Acknowledgement of Paternity Project
MAPSIS	Maine Adult Protective Services Information System
MAR	Marriage(s)
MARCC	Maine At-Risk Childcare Program
MARLAP	Multi Agency Radiation Laboratory Accreditation Program
MARS	Management Analysis Reporting System
MARSSIM	Multi Agency Radioactive Site Survey Investigation Manual
mAs	MilliAmps Seconds
MBCHP	Maine Breast & Cervical Health Programs
MBDE	Maine Board of Dental Examiners
MBM	MaineCare Benefits Manual
MC	Maine Care
MCA	Maine Children's Alliance
MCCDA	Maine Child Care Directors Association
MCD	Minor Civil Division
MCD	Medical Care Development
MCF	Maine Caring Families
MCH	Maternal and Child Health
MCH	Maternal and Child Health Program
MCHB	Maternal Child Health Bureau
MCHBG	Maternal and Child Health Block Grant
MCHBG	Maternal Child Health Block Grant
MCHC	Maine Cardiovascular Health Council
MCHN	Maternal Child Health Nutrition
MCL	Maximum Contaminant Level
MCLG	Maximum Contaminant Level Goal
MCLPPP	Maine Childhood Lead Poisoning Prevention Program
MCO	Managed Care Organization
MCR	Maine Cancer Registry
MCSEM	Maine Child Support Enforcement Manual
MCVHP	Maine Cardiovascular Health Program
MD	Medical Doctor
MDA	Maine Dental Association
MDAC	Maine Dental Access Coalition
MDHA	Maine Dental Hygienists' Association
MDS	Minimum Data Set
MDT	Multidisciplinary Team
MECAPS	Maine Enrollment & Capitation System
MECARE	Maine Eligibility System for Long-term Care Enrollment (BEAS)
MeCASA	Maine Court Appointed Special Advocates

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MECMS	Maine Claims Management System
MED	Medical Eligibility Determination
MEJP	Maine Equal Justice Partners, Inc. (Advocates)
MEMA	Maine Emergency Management Agency
MEPOPS	Maine Point of Purchase System – online system connecting all Maine Pharmacies
MESC	Maine Employment Security Commission
MFASIS	Maine Financial and Administration Services Information System
MFCU	Maine Fraud Control Unit
MGMC	Maine General Medical Center
MH	Mental Health (now BDS)
MHDO	Maine Health Data Organization
MHIC	Maine Health Information Center
MHMR	Mental Health, Mental Retardation (now BDS)
MHP	Maine Health Program
MHRT	Mental Health Rehabilitative Technician
MI/MR	Mental Illness/Mental retardation
MIA	Monthly Income Allocation
MICAR	Mortality Indexing Classification and Retrieval
MIF	Medical Information Form
MIP	Maine Immunization Program
MIPP	Maine Injury Prevention Program
MIRU	Letters to Providers
MIS	Management Information System
MIS	Minimum Income Standard
MLCE	Maine Law and Civics Education
MMA	Maine Municipal Association
MMAL	Maine Maximum Allowable Cost
MMAM	Maine Medical Assistance Manual
MMC	Maine Medical Center
MMDSS	Maine Medicaid Decision Support System
MMIS	Medicaid Management Information Systems
MMNA	Monthly Maintenance Needs Allowance (Monthly Income Allowance)
MMR	Measles, Mumps, Rubella
MN	Medically Needy
MNN	Maine Nutrition Network
Modular	Technical design characteristic ensuring standardized structure for flexible use
MOE	Maintenance of Effort
MOGE	Moved or Gone Elsewhere
MOP	Model Office Project
MOU	Memorandum of Understanding
MPCA	Maine Primary Care Association
MPHIS	Maine Public Health Information System
MQC	Quality
MQSA	Mammography Quality Standards Act
MR	Monthly Report
MR	Mental Retardation
MRA	Maine Restaurant Association
MRSA	Maine Revised Statutes Annotated
MRT	Medical Review Team
MSA	Metropolitan Statistical Area
MSA	Medicaid State Agency
MSAD	Maine School Admin. District
MSD	Merck/Sharp/Dohme
MSEA	Maine State Employees Association
MSECCA	Maine State Employees' Combined Charitable Appeal
MSG	Managing in State Government
MSHA	Maine State Housing Authority

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MSIS	Medicaid Statistical Information System
MSRS	Maine State Retirement System
MSW	Master of Social Work; also, Medical Social Worker
MSWC	Medical Social Worker Consultant
MTD	Month-to-Date
MTS	Medicare Transaction System
MTSC	Maine Traffic Safety Coalition
MUA	Medically Underserved Area
MUP	Medically Underserved Population
MY	Maine Yankee (Nuclear Power Plant)
MYAPC	Maine Yankee Atomic Power Company
MYC	Maine Youth Center
MYCA	Maine Youth Camping Association
MYSPP	Maine Youth Suicide Prevention Program
NAACCR	North American Association of Central Cancer Registries
NAMI	National Alliance for the Mentally Ill
NARM	Naturally or Accelerator produced Radioactive Materials
NAS	National Academy of Sciences
NASD	National Association of Security Dealers
NASDA	National Association of State Departments of Agriculture
NB	Newborn
NBS	Newborn Screening
NCAI	National Coalition for Adult Immunization
NCANDS	National Child Abuse and Neglect Data System
NCC	Nursing Care Center
NCCNHR	National Citizens Coalition for Nursing Home Reform
NCDHM	National Children's Dental Health Month
NCHS	National Center for Health Statistics
NCI	National Cancer Institute
NCIPC	National Center for Injury Prevention and Control of CDC
NCP	Non Custodial Parent
NCPCA/N	National Committee for Prevention of Child Abuse and Neglect
NCPDP	National Council on Prescription Drug Programs
NCQA	National Committee for Quality Assurance
NCRA	National Cancer Registrars Association
NCRP	National Commission on Radiation Protection
NCSC	National Council for Senior Citizens
NCWS	Non-Community Water System
NDC	National Drug Code/National Drug Classification
NDNH	National Directory of New Hires
NDPS	Novell Distributed Printing Service
NDS	Novell Directory Services
NDSL	National Direct Student Loan
NECSES	New England Child Support Enforcement System
NEDD(F)	Northeast Delta Dental (Foundation)
NEFDOA	North East Food and Drug Officials Association
NEHA	National Environmental Health Association
NEP	New England Partners
NEPA	National Environmental Policy Act
NERHC	New England Radiological Health Committee
NF	Nursing Facility
NF	Nursing Facilities

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NFPA	National Fire Protection Administration
NFSI	Net Food Stamp Income
NGA	National Governor's Association
NH	Nursing Home
NHAA	Nursing Home Analysis Area
NHO	National Hospice Organization
NHP	Newborn Hearing Program
NHSC	National Health Service Corps
NHTSA	National Highway Traffic Safety Administration
NHUA	Non-Heat Utilities Allowance
NIH	National Institute of Health
NIMH	National Institutes of Mental Health
NIOSH	National Institute for Occupational Safety and Health
NIP	National Immunization Program
NIQCS	National Integrated Quality Control System
NIST	National Institute of Standards & Technology
NMMC	Northern Maine Medical Center
NOAA	National Oceanic and Atmospheric Administration
NOD	Notice of Debt
NOHC	National Oral Health Conference
NOPECS	Notice of Proceeding to Establish Child Support
NORM	Naturally Occurring Radioactive Materials
NOV	Notice of Violation
NP	Nurse Practitioner
NPCR	National Program of Cancer Registries
NPCR	National Program for Cancer Registries
NPDES	National Pollutant Discharge Elimination System
NPP	Notice of Paternity Proceedings
NPS	Nonpoint Source
NRC	National Research Council
NRC	Nuclear Regulatory Commission
NRCS	Natural Resource Conservation Service
NRRPT	National Registry of Radiation Protection Technologists
NSCLC	National Senior Citizens Law Center
NSF	National Sanitation Foundation
NSPI	National Spa and Pool Institute
NWPA	Nuclear Waste Policy Act
NYLCare	Private HMO (formerly contracted with BMS)
OASIS	Organization for the Advancement of Structured Information Standards
OASIS	Outcomes Assessment Information Act
OBRA	Omnibus Budget Reconciliation Act
OC	Open Competitive
OCCHS	Office of Child Care and Head Start
OCR	Office of Civil Rights
OCR	Optical Character Recognition
OCSE	Office of Child Support Enforcement (HHS)
ODIE	On-line Data Input and Edit
ODRVS	Office of Data Research & Vital Statistics
OED	Office of the Executive Director
OGC	Office of General Council (NRC)
OGWDW	Office of Ground Water and Drinking Water
OHDPM	Offices of health Data and Program management
OHP	Oral Health Program
OHP	Office of Health Policy
OHP	Oral Health Program

Index of Acronyms

OIG	Office of Inspector General (federal)
OJT	On-the-Job Training
OLAP	Online Analytical Processing
OM	Office Manager
OMAHA	
OSA	Office of Substance Abuse
OT	Occupational Therapy
OT	Over Time
PaS	Parents as Scholars
PCS	Personal Care Services
PDN	Private Duty Nurse
PHN/ W&CPHS	Public Health Nursing/Women & Children Preventive Health Services
PNMI	Private Non-Medical Institutions
PSSP	Priority Social Services Program
PT	Physical Therapy
PT	Part Time
QI	Quality Improvement
RFP	Request For Proposal
RPC	Riverview Psychiatric Center
SAPTBG	Substance Abuse Prevention and Treatment Block Grant
SFY 06	State Fiscal Year
SSI	Supplemental Security Income
ST	Speech Therapy
SURS	Surveillance, Utilization and Review
TANF	Temporary Assistance for Needy Families
TBI	Traumatic Brain Injury
TCM	Targeted Case Management
TPL	Third Party Liability
UHUD	Housing and Urban Development